471-000-71 Form MS-65, "Medicaid Medical Transportation Services Authorization and Claim Form" and Completion Instructions

MEDICAID MEDICAL TRANSPORTATION SERVICES
AUTHORIZATION AND CLAIM FORM
Health and Human Services Finance and Support

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Client's Name	2. Medicaid ID #
Last Name First Name	

3. Date of Trip/Service	Place of Service	Procedure Code	DX Code	Charges	Number of Services
A.	41		7999		
B.	41		7999		
		4. TOTAL CHARGES			

SIGNATURE OF PROVIDER: I certify that (1) the services listed on this claim were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction; (2) the charge for such services are just, unpaid, actually due according to law and program and not in excess of regular fees; (3) the information provided on this claim is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.

5. Date	6. Signature of Provider
	SIGN HERE

7. Medicaid Provider Number	Provider Name (Printed)	Telephone ( )	
Address	City	State	Zip

FOR MEDICAID USE ONLY	
Date of Trip	Appointment Time
Pickup Address	
Destination	
Pickup Time	# of Trips Authorized
Parent/Guardian Name	
Signature of Authorizing Agent	Date Authorized

Health and Human Services Finance and Support, Claims Processing, PO Box 95026, Lincoln, NE 68509-5026

Instructions for Completing Form MS-65, "Medicaid Medical Transportation Services Authorization and Claim Form"

Use: Providers use Form MS-65 to bill Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered medical transportation services arranged and authorized by the authorizing agency contracting with the Health and Human Services Finance and Support.

Medicaid policy for medical transportation services is covered in 471 NAC 27-000.

Completion: Form MS-65 is partially completed by the authorizing agency when authorizing medical transportation services and sent to the transportation provider. After the service has been provided, the transportation provider completes the fields identified with an asterisk (*). Other fields are preprinted or completed by the authorizing agency. The numbers listed below correspond to the numbers of the fields on the form.

1. **CLIENT'S NAME:** The authorizing agency will enter the full name (last name, first name) of the Medicaid client authorized to receive services.

2. **MEDICAID ID#:** The authorizing agency will enter the Medicaid client's complete eleven-digit identification number (Example: 123456789-01).

*3. ***DATE OF SERVICE/TRIP:** Enter the numeric date the authorized service was provided. Bill all trips provided on a single day on one line of the claim form.

   PLACE OF SERVICE: The place of service code is preprinted on the form.

   PROCEDURE CODE: The procedure code is preprinted on the form.

   DX CODE: The diagnosis code is preprinted on the form.

   ***CHARGES:** Enter the total customary charge for all trips billed on each date of service.

   ***NUMBER OF SERVICES:** Enter the number of trips provided on each date of service.

*4. **TOTAL CHARGES:** Enter the total of all charges in Field 3.

*5. **DATE:** The provider or authorized representative must date the claim form. The signature date must be on or after the dates of service listed on the claim.

*6. **SIGNATURE:** The provider or authorized representative must sign the claim form. A signature stamp, computer-generated or typewritten signature will be accepted.

7. **MEDICAID PROVIDER NUMBER:** The provider's eleven-digit Nebraska Medicaid provider number assigned by Medicaid is preprinted on the form.

8. **PROVIDER NAME AND ADDRESS:** The provider's name, address and phone number is preprinted on the form.

The authorizing agency will complete the section labeled "FOR MEDICAID USE ONLY". Providers shall not complete or alter any portion of this section.

CLAIM SUBMITTAL: Send the ORIGINAL of the completed Form MS-65 to:

Medicaid Claims Processing
Health and Human Services Finance and Support
P.O. Box 95026
Lincoln, NE 68509-5026

INQUIRIES: For inquiries regarding Medicaid claims, contact Medicaid Inquiry at 471-9128 (in Lincoln) or (877) 255-3092 (outside Lincoln). Medicaid Inquiry is available from 8:00 a.m. to 5:00 p.m. (Central Time) on Monday through Friday.